

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016824

STATE FILE NUMBER 569

JUN 8 1959

Registration District No. 042

Primary Registration District No. 1000

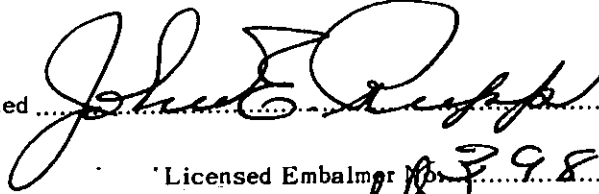
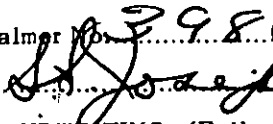
Registrar's No. 569

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR St. Joseph TOWN		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 215 E Mo. Ave		d. STREET ADDRESS 215 E Mo. Ave	
Length of stay in lb 70 yrs		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Elizabeth McCance		4. DATE OF DEATH Month Day Year May 27, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper		11. BIRTHPLACE (City and state or country) St. Joseph, Mo	
13a. FATHER'S NAME Michael Lorey		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT rs. Leo Salsberry St. Joseph, Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200			INTERVAL BETWEEN ONSET AND DEATH Unk. Unk.
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Jan. 18, 1957 to May 27, '59 and last saw her alive on May 26, 1959 Death occurred at 4:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Collis Rounby M.D.		22b. ADDRESS Kirtpatrick Bldg	
22c. DATE SIGNED		22d. DATE RECD. BY LOCAL REG.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/28/59	
23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery		23d. LOCATION (City, town, or county) (State) St Joseph, Mo	
24. FUNERAL DIRECTOR John E. ...		26. REGISTRAR'S SIGNATURE Miss Clark ...	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, ~~or by~~, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed 
Licensed Embalmer No. 398
P. O. Address 

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.